Insurance Information

Please fill out if you have not already given this information when your appointment was made

NAME OF PATIENT _____ DATE OF BIRTH_____

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

HAVE YOU HAD PREVIOUS PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR

SPEECH THERAPY THIS CALENDAR YEAR? YES NO

IF YES, HOW MANY VISITS_____

PLEASE CHECK THE CATEGORY OF INJURY RELATED TO YOUR PHYSICAL THERAPY APPOINTMENT ☐ AUTO, ☐ WORK, ☐ HOME, ☐ OTHER

IF OTHER, PLEASE EXPLAIN

_____

IS THERE LEGAL ACTION PENDING? YES NO

ATTORNEY'S NAME _____

ADDRESS _____

TELEPHONE _____

FAX # _____

WORKERS COMPENSATION CARRIER _____

CLAIM NUMBER _____

NAME OF ADJUSTER _____

TELEPHONE NUMBER _____

FAX NUMBER _____

Orthosport Physical Therapy